LET'S CODE IT!

Shelley C. Safian
PhD, RHIA, MAOM/HSM/HI, CCS-P, COC, CPC-I

Mary A. Johnson
MBA-HM-HI, CPC

Mc Graw Hill Education

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Shelley C. Safian, PhD, RHIA

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AHIMA-Approved ICD-10-CM/PCS Trainer

Mary A. Johnson, MBA-HM-HI, CPC

Central Carolina Technical College

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This book is printed on acid-free paper.

1 2 3 4 5 6 7 8 9 LSC 21 20 19 18

ISBN 978-1-259-82873-7
MHID 1-259-82873-5

Senior Portfolio Manager: *William Mulford*
Senior Product Developer: *Michelle Flomenhoft*
Product Developer: *Michelle Gaseor*
Executive Marketing Manager: *Roxan Kinsey*
Senior Content Project Managers: *Sherry Kane/Brent dela Cruz*
Senior Buyer: *Laura Fuller*
Senior Design: *Tara McDermott*
Lead Content Licensing Specialist: *Beth Thole*
Cover Image: ©*Ingram Publishing*
Compositor: *SPi Global*

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Library of Congress Cataloging-in-Publication Data

Names: Safian, Shelley C., author. | Johnson, Mary A. (Medical record coding program manager) author.
Title: Let's code it! / Shelley C. Safian, PhD, RHIA, MAOM/HSM, CCS-P, CPC-H, CPC-I, AHIMA-Approved ICD-10-CM/PCS Trainer, Mary A. Johnson, CPC, Central Carolina Technical College.
Description: First edition. | New York, NY : McGraw-Hill Education, [2019] | Includes index.
Identifiers: LCCN 2017025623 | ISBN 9781259828737 (alk. paper)
Subjects: LCSH: Nosology—Code numbers.
Classification: LCC RB115 .S24 2019 | DDC 616.001/2—dc23 LC record available at https://lccn.loc.gov/2017025623

The Internet addresses listed in the text were accurate at the time of publication. The inclusion of a website does not indicate an endorsement by the authors or McGraw-Hill Education, and McGraw-Hill Education does not guarantee the accuracy of the information presented at these sites.

ABOUT THE AUTHORS

Shelley C. Safian

Courtesy of Shelley C. Safian

Shelley Safian has been teaching medical coding and health information management for more than 15 years, at both on-ground and online campuses. In addition to her regular teaching responsibilities at University of Central Florida and Berkeley College Online, she often presents seminars sponsored by AHIMA and AAPC, writes regularly about coding for the *Just Coding* newsletter, and has written articles published in AAPC's *Healthcare Business Monthly, SurgiStrategies,* and *HFM* (Healthcare Financial Management) magazine. Safian is the course author for multiple distance education courses on various coding topics, including ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Level II coding.

Safian is a Registered Health Information Administrator (RHIA) and a Certified Coding Specialist–Physician-based (CCS-P) from the American Health Information Management Association and a Certified Outpatient Coder (COC) and a Certified Professional Coding Instructor (CPC-I) from the American Academy of Professional Coders. She is also a Certified HIPAA Administrator (CHA) and has earned the designation of AHIMA-Approved ICD-10-CM/PCS Trainer.

Safian completed her Graduate Certificate in Health Care Management at Keller Graduate School of Management. The University of Phoenix awarded her the Master of Arts/Organizational Management degree and a Graduate Certificate in Health Informatics. She earned her Ph.D. in Health Care Administration with a focus in Health Information Management.

Mary A. Johnson

Courtesy of Mary A. Johnson

Mary Johnson is currently the Medical Record Coding Program Director at Central Carolina Technical College, Sumter, South Carolina. Her background includes corporate training as well as on-campus and online platforms. Johnson also designs and implements customized coding curricula. Johnson received her Bachelor of Arts dual degree in Business Administration and Marketing from Columbia College, and earned a Masters of Business Administration with a dual focus in Healthcare Management and Health Informatics from New England College. Johnson is a Certified Professional Coder (CPC) credentialed through the American Academy of Professional Coders and is ICD-10-CM proficient.

Acknowledgments

—This book is dedicated to all of those who have come into my life sharing encouragement and opportunity to pursue work that I love; for the benefit of all of my students: past, present, and future.—*Shelley*

—This book is dedicated in loving memory of my parents, *Dr. and Mrs. Clarence J. Johnson Sr.,* for their love and support. Also, to those students with whom I have had the privilege to work and to those students who are beginning their journey into the world of medical coding.—*Mary*

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Let's Code It! ICD-10-CM: includes Parts 1, 2 and 6
Let's Code It! ICD-10-CM, ICD-10-PCS: includes Parts 1, 2, 5 and 6
Let's Code It! Procedure: includes Parts 1 and 3-6

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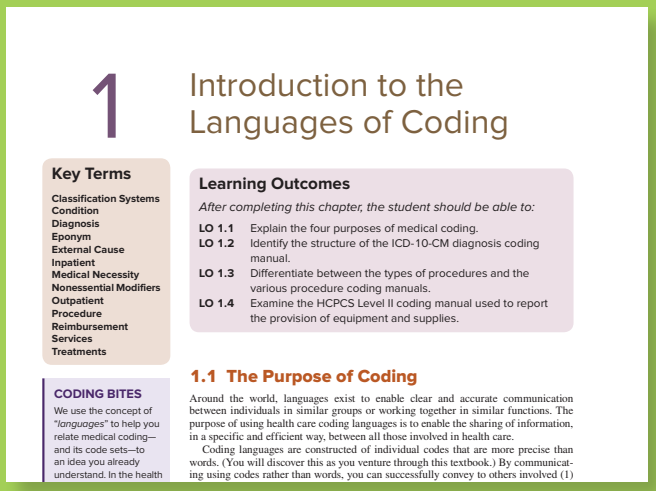
GUIDED TOUR

Let's Code It! was developed with student success in mind: success in college, success taking the certification exam, and success in their future health care career.

Chapter Openers

Each chapter begins by clearly identifying the **Learning Outcomes** students need to master along with the **Key Terms** that they need to learn.



1 Introduction to the Languages of Coding

Key Terms

Classification Systems
Condition
Diagnosis
Eponym
External Cause
Inpatient
Medical Necessity
Nonessential Modifiers
Outpatient
Procedure
Reimbursement
Services
Treatments

Learning Outcomes

After completing this chapter, the student should be able to:

LO 1.1 Explain the four purposes of medical coding.
LO 1.2 Identify the structure of the ICD-10-CM diagnosis coding manual.
LO 1.3 Differentiate between the types of procedures and the various procedure coding manuals.
LO 1.4 Examine the HCPCS Level II coding manual used to report the provision of equipment and supplies.

CODING BITES

We use the concept of "*languages*" to help you relate medical coding—and its code sets—to an idea you already understand. In the health

1.1 The Purpose of Coding

Around the world, languages exist to enable clear and accurate communication between individuals in similar groups or working together in similar functions. The purpose of using health care coding languages is to enable the sharing of information, in a specific and efficient way, between all those involved in health care.

Coding languages are constructed of individual codes that are more precise than words. (You will discover this as you venture through this textbook.) By communicating using codes rather than words, you can successfully convey to others involved (1)

Coding Bites

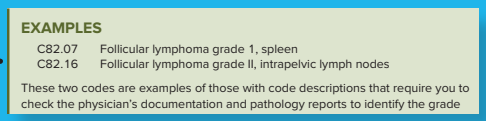
These appear throughout the text to highlight key concepts and tips to further support understanding and learning.

CODING BITES

This is just an overview to help you orient yourself to the structure of the code book. You will learn, in depth, how to use the ICD-10-CM code set to report any and all of the reasons *why* a patient needs the care of a health care professional in *Part II: Reporting Diagnoses.*

Examples, Let's Code It! Scenarios, and You Code It! Case Studies

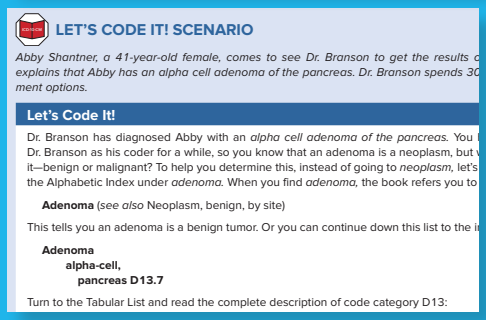
Examples are included throughout each chapter to help students make the connection between theoretical and practical coding. **Let's Code It! Scenarios** walk students through abstracting and the coding process, step-by-step, to determine the correct code. And **You Code It! Case Studies** provide students with hands-on practice coding scenarios and case studies throughout each chapter. In addition, **You Interpret It!** questions present opportunities for students to use critical-thinking skills to identify details needed for accurate coding.



EXAMPLES

C82.07 Follicular lymphoma grade 1, spleen
C82.16 Follicular lymphoma grade II, intrapelvic lymph nodes

These two codes are examples of those with code descriptions that require you to check the physician's documentation and pathology reports to identify the grade



LET'S CODE IT! SCENARIO

Abby Shantner, a 41-year-old female, comes to see Dr. Branson to get the results o explains that Abby has an alpha cell adenoma of the pancreas. Dr. Branson spends 30 ment options.

Let's Code It!

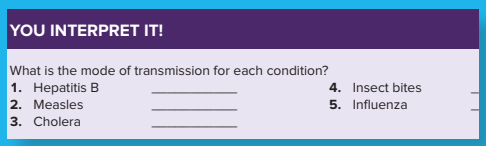
Dr. Branson has diagnosed Abby with an *alpha cell adenoma of the pancreas.* You Dr. Branson as his coder for a while, so you know that an adenoma is a neoplasm, but it—benign or malignant? To help you determine this, instead of going to *neoplasm,* let's the Alphabetic Index under *adenoma.* When you find *adenoma,* the book refers you to

Adenoma (*see also* Neoplasm, benign, by site)

This tells you an adenoma is a benign tumor. Or you can continue down this list to the

Adenoma
alpha-cell,
pancreas D13.7

Turn to the Tabular List and read the complete description of code category D13:



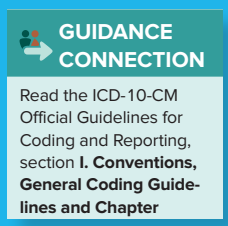
YOU INTERPRET IT!

What is the mode of transmission for each condition?

1. Hepatitis B _____
2. Measles _____
3. Cholera _____
4. Insect bites _____
5. Influenza _____

Guidance Connections

Each of these boxes connects the concepts students are learning in the chapter to the related, specific Official Guidelines in order to further students' knowledge and understanding of coding resources.

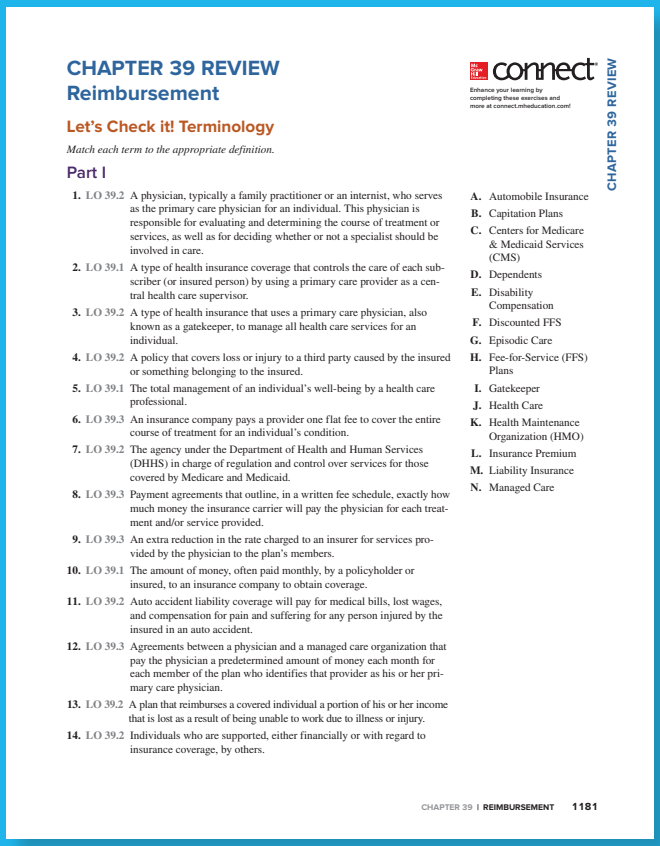


GUIDANCE CONNECTION

Read the ICD-10-CM Official Guidelines for Coding and Reporting, section **I. Conventions, General Coding Guidelines and Chapter**

End-of-Chapter Reviews

Most chapters end with the following assessment types to reinforce the chapter learning outcomes: Let's Check It! Terminology; Let's Check It! Concepts; Let's Check It! Guidelines; Let's Check It! Rules and Regulations; and You Code It! Basics.



CHAPTER 39 REVIEW
Reimbursement

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CHAPTER 39 REVIEW

Let's Check it! Terminology

Match each term to the appropriate definition.

Part I

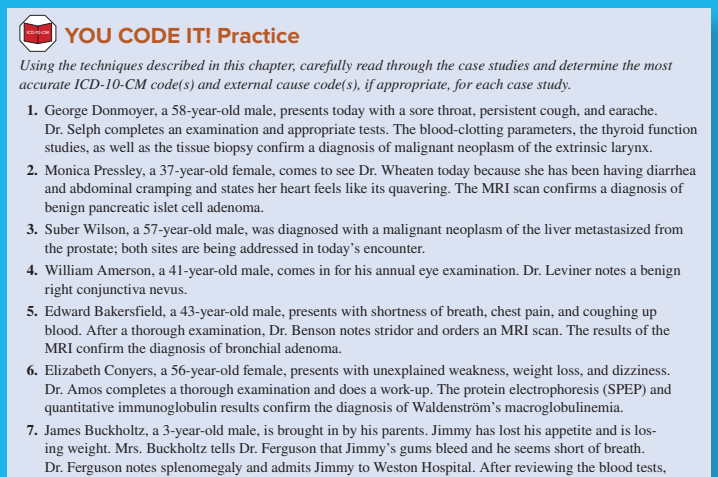
1. LO 39.2 A physician, typically a family practitioner or an internist, who serves as the primary care physician for an individual. This physician is responsible for evaluating and determining the course of treatment or services, as well as for deciding whether or not a specialist should be involved in care.
2. LO 39.1 A type of health insurance coverage that controls the care of each subscriber (or insured person) by using a primary care provider as a central health care supervisor.
3. LO 39.2 A type of health insurance that uses a primary care physician, also known as a gatekeeper, to manage all health care services for an individual.
4. LO 39.2 A policy that covers loss or injury to a third party caused by the insured or something belonging to the insured.
5. LO 39.1 The total management of an individual's well-being by a health care professional.
6. LO 39.3 An insurance company pays a provider one flat fee to cover the entire course of treatment for an individual's condition.
7. LO 39.2 The agency under the Department of Health and Human Services (DHHS) in charge of regulation and control over services for those covered by Medicare and Medicaid.
8. LO 39.3 Payment agreements that outline, in a written fee schedule, exactly how much money the insurance carrier will pay the physician for each treatment and/or service provided.
9. LO 39.3 An extra reduction in the rate charged to an insurer for services provided by the physician to the plan's members.
10. LO 39.1 The amount of money, often paid monthly, by a policyholder or insured, to an insurance company to obtain coverage.
11. LO 39.2 Auto accident liability coverage will pay for medical bills, lost wages, and compensation for pain and suffering for any person injured by the insured in an auto accident.
12. LO 39.3 Agreements between a physician and a managed care organization that pay the physician a predetermined amount of money each month for each member of the plan who identifies that provider as his or her primary care physician.
13. LO 39.2 A plan that reimburses a covered individual a portion of his or her income that is lost as a result of being unable to work due to illness or injury.
14. LO 39.2 Individuals who are supported, either financially or with regard to insurance coverage, by others.

A. Automobile Insurance
B. Capitation Plans
C. Centers for Medicare & Medicaid Services (CMS)
D. Dependents
E. Disability Compensation
F. Discounted FFS
G. Episodic Care
H. Fee-for-Service (FFS) Plans
I. Gatekeeper
J. Health Care
K. Health Maintenance Organization (HMO)
L. Insurance Premium
M. Liability Insurance
N. Managed Care

CHAPTER 39 | REIMBURSEMENT 1181

Real Abstracting Practice with You Code It! Practice, You Code It! Application, and Capstone Case Studies Chapters

Gain real-world experience by using actual patient records (with names and other identifying information changed) to practice ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Level II coding for both inpatients and outpatients. *You Code It! Practice* exercises give students the chance to practice coding with short coding scenarios. *You Code It! Application* exercises give students the chance to review and abstract physicians' notes documenting real patient encounters in order to code those scenarios. Both of these types of exercises can be found at the end of most chapters. *Capstone Chapters* come at the end of Parts II–V and include 15 additional real-life outpatient and inpatient case studies to help students synthesize and apply what they have learned through hands-on coding practice with each code set.



YOU CODE IT! Practice

Using the techniques described in this chapter, carefully read through the case studies and determine the most accurate ICD-10-CM code(s) and external cause code(s), if appropriate, for each case study.

1. George Donmoyer, a 58-year-old male, presents today with a sore throat, persistent cough, and earache. Dr. Selph completes an examination and appropriate tests. The blood-clotting parameters, the thyroid function studies, as well as the tissue biopsy confirm a diagnosis of malignant neoplasm of the extrinsic larynx.
2. Monica Pressley, a 37-year-old female, comes to see Dr. Wheaten today because she has been having diarrhea and abdominal cramping and states her heart feels like its quavering. The MRI scan confirms a diagnosis of benign pancreatic islet cell adenoma.
3. Suber Wilson, a 57-year-old male, was diagnosed with a malignant neoplasm of the liver metastasized from the prostate; both sites are being addressed in today's encounter.
4. William Amerson, a 41-year-old male, comes in for his annual eye examination. Dr. Leviner notes a benign right conjunctiva nevus.
5. Edward Bakersfield, a 43-year-old male, presents with shortness of breath, chest pain, and coughing up blood. After a thorough examination, Dr. Benson notes stridor and orders an MRI scan. The results of the MRI confirm the diagnosis of bronchial adenoma.
6. Elizabeth Conyers, a 56-year-old female, presents with unexplained weakness, weight loss, and dizziness. Dr. Amos completes a thorough examination and does a work-up. The protein electrophoresis (SPEP) and quantitative immunoglobulin results confirm the diagnosis of Waldenström's macroglobulinemia.
7. James Buckholtz, a 3-year-old male, is brought in by his parents. Jimmy has lost his appetite and is losing weight. Mrs. Buckholtz tells Dr. Ferguson that Jimmy's gums bleed and he seems short of breath. Dr. Ferguson notes splenomegaly and admits Jimmy to Weston Hospital. After reviewing the blood tests,

In addition, all of the exercises in the Chapter Review can be assigned through Connect. Of particular note are the ***You Code It! Practice*** exercises, which offer our unique **CodePath** option. In Connect, students are presented with a series of questions to guide them through the critical thinking process to determine the correct code.

YOU CODE IT! Application

The following exercises provide practice in abstracting physician documentation from our health care facility, Prader, Bracker, & Associates. These case studies are modeled on real patient encounters. Using the techniques described in this chapter, carefully read through the case studies and determine the most accurate ICD-10-CM code(s) for each case study. Remember to include external cause codes, if appropriate.

PRADER, BRACKER, & ASSOCIATES

A Complete Health Care Facility

159 Healthcare Way • SOMEWHERE, FL 32811 • 407-555-6789

PATIENT: Kassandra, Kelly

ACCOUNT/EHR #: KASSKE001

DATE: 09/16/18

Attending Physician: Oscar R. Prader, MD

S: Pt is a 19-year-old female who has had a sore throat and cough for the past week. She states that she had a temperature of 101.5 F last night. She also admits that it is painful to swallow. No OTC medication has provided any significant relief.

O: Ht 5′5″ Wt. 148 lb. R 20. T 101 F. BP 125/82. Pharynx is inspected, tonsils enlarged. There is pus noted in the posterior pharynx. Neck: supple, no nodes. Chest: clear. Heart: regular rate and rhythm without murmur.

A: Acute pharyngitis

P: 1. Send pt for Strep test

2. Recommend patient gargle with warm salt water and use OTC lozenges to keep throat moist

3. Rx if needed once results of Strep test come back

4. Return in 2 weeks for follow-up

ORP/pw D: 9/16/18 09:50:16 T: 9/18/18 12:55:01

Determine the most accurate ICD-10-CM code(s).

WESTON HOSPITAL

629 Healthcare Way • SOMEWHERE, FL 32811 • 407-555-6541

PATIENT: DAVIS, HELEN

ACCOUNT/EHR #: DAVIHE001

DATE: 10/21/18

Attending Physician: Renee O. Bracker, MD

PREFACE

Welcome to *Let's Code It!* This product is part of a multipart series that instructs students on how to become proficient in medical coding—a health care field that continues to be in high demand. The Bureau of Labor Statistics notes the demand for health information management professionals (which includes coders) will continue to increase incredibly through 2024 and beyond.

Let's Code It! provides a 360-degree learning experience for anyone interested in the field of medical coding, with strong guidance down the path to coding certification. Theory is presented in easy-to-understand language and accompanied by lots of examples. Hands-on practice is included with real-life physician documentation, from both outpatient and inpatient facilities, to promote critical thinking analysis and evaluation. This is in addition to determination of accurate codes to report diagnoses, procedures, and ancillary services. All of this is assembled to support the reader's development of a solid foundation upon which to build a successful career after graduation.

The Safian/Johnson Medical Coding series includes the following products:

Let's Code It!
Let's Code It! ICD-10-CM
Let's Code It! ICD-10-CM/PCS
Let's Code It! Procedure
You Code It! Abstracting Case Studies Practicum, 3e

The different solutions are designed to fit the most common course content selections. *Let's Code It!* is the comprehensive offering with coverage of ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Level II.

These products are further designed to give your students the medical coding experience they need in order to pass their first medical coding certification exams, such as the CCS/CCS-P or CPC/COC. The products offer students a variety of practice opportunities by reinforcing the learning outcomes set forth in every chapter. The chapter materials are organized in short bursts of text followed by practice—keeping students active and coding! These products were developed based on the 2017 code sets, with 2018 updates implemented as much as possible prior to publication. Updates will be made to the answer keys and Connect exercises on an annual basis.

Here's What You Can Expect from ***Let's Code It!***

- Each of the six parts of this product includes an Introduction to provide students with an overview of the information within that part and how they can use this knowledge.
  - Part I: Medical Coding Fundamentals
  - Part II: Reporting Diagnoses
  - Part III: Reporting Physicians Services and Outpatient Procedures
  - Part IV: DMEPOS & Transportation
  - Part V: Inpatient (Hospital) Reporting
  - Part VI: Legal, Ethical, and Reimbursement Issues

- **Part I: Medical Coding Fundamentals** helps students build a strong theoretical foundation regarding the various code sets. The chapters teach students how and when each code set is used and how to abstract documentation. These chapters also teach them how to use a solid coding process, including the importance of queries, how to write a legal query, exposure to the Official Guidelines, and confirmation of medical necessity.
- **Part II: Reporting Diagnoses** provides students with an incremental walkthrough of the ICD-10-CM code set.
- **Part III: Reporting Physicians Services and Outpatient Procedures** provides students with a progressive learning experience for using CPT® procedure codes.
- **Part IV: DMEPOS & Transportation** gives students insight into, and hands-on practice using, the HCPCS Level II code set to report the provision of durable medical equipment, prosthetics, orthotics, and other medical supplies.
- **Part V: Inpatient (Hospital) Reporting** shows students how to build an accurate ICD-10-PCS code to report inpatient procedures, services, and treatments.
- The coding chapters in Parts II–V all include real-life scenarios, as well as physician documentation mainly in the form of procedure notes and operative reports (both inpatient and outpatient) for students to practice abstracting and coding.
  - *Let's Code It! Scenarios* provide step-by-step instruction so students can learn to use their critical-thinking skills throughout the coding process to determine the correct code.
  - *You Code It! Case Studies* provide students with hands-on practice coding scenarios and case studies throughout each chapter.
  - *You Interpret It!* questions present additional opportunities for students to use critical-thinking skills to identify details required for accurate coding.
  - *Chapter Reviews* include assessments of chapter concepts:
    - Let's Check It! Terminology
    - Let's Check It! Concepts
    - Let's Check It! Guidelines
    - Let's Check It! Rules and Regulations
    - You Code It! Basics
    - You Code It! Practice Case Studies
    - You Code It! Application Case Studies
- *Examples* are included throughout each chapter to help students make the connection between theoretical and practical coding.
- *Coding Bites* highlight key concepts and tips to further support understanding and learning.
- *Guidance Connection* features point to the specific Official Guideline applicable for the concept being discussed.
- *Capstone Chapters* come at the end of Parts II–V with 15 additional real-life outpatient and inpatient case studies to help students synthesize and apply what they have learned through hands-on coding practice with each code set.
- **Part VI: Legal, Ethical, and Reimbursement Issues** provides a concise overview connecting these broad topics to a professional coding specialist's job requirements.
- *Examples* again take students through real-life scenarios to help them understand how they will use this information.
- *Coding Bites* provide tips and highlight key concepts.
- This part also includes material to teach students how to access credible resources on the Internet.

- *Codes of Ethics* from both AHIMA and AAPC are included as well as information on compliance plans.
- *You Interpret It!* questions present students with opportunities to use critical-thinking skills to identify details required for accurate job performance.
- *Chapter Reviews* include assessments of chapter concepts:
    - Let's Check It! Terminology
    - Let's Check It! Concepts
    - Let's Check It! Which Type of Insurance?
    - Let's Check It! Rules and Regulations
    - You Code It! Application Case Studies

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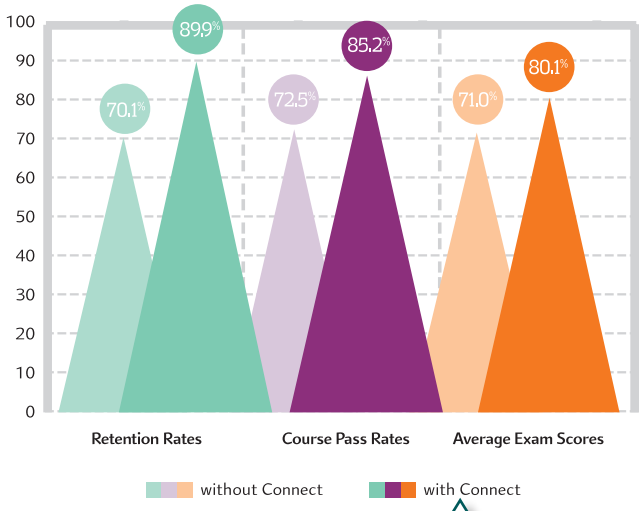

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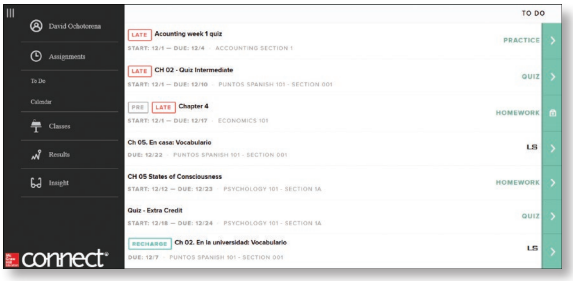

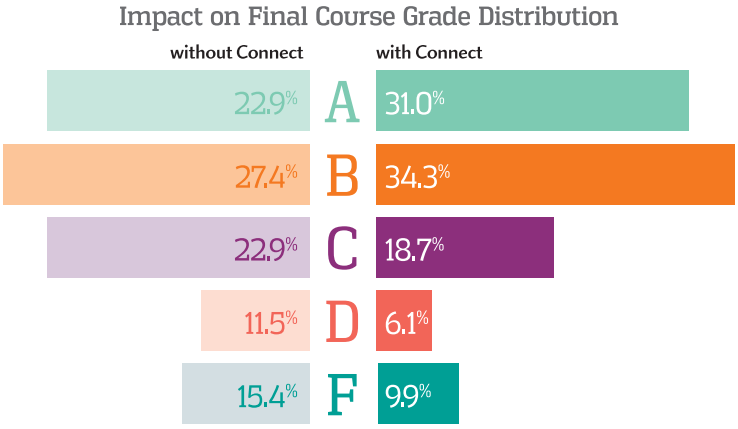

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CONNECT FOR YOU CODE IT!

McGraw-Hill Connect for You Code It! will include:

- All end-of-chapter questions
- CodePath versions of You Code It! practice questions, in which students are presented with a series of questions to guide them through the critical thinking process to determine the correct code
- Interactive Exercises, such as Matching, Sequencing, and Labeling activities
- Testbank questions
- Lecture-style videos, which will provide additional guidance on challenging coding questions

INSTRUCTORS' RESOURCES

You can rely on the following materials to help you and your students work through the material in the book; all are available in the Instructor Resources under the Library tab in *Connect* (available only to instructors who are logged in to *Connect*).

Supplement	**Features**
Instructor's Manual (organized by Learning Outcomes)	• Lesson plans • Answer keys for all exercises
PowerPoint Presentations (organized by Learning Outcomes)	• Key terms • Key concepts • Accessible
Electronic Testbank	• Computerized and *Connect* • Word version • Questions are tagged with learning outcomes; level of difficulty; level of Bloom's taxonomy; feedback; and ABHES, CAAHEP, and CAHIIM competencies.
Tools to Plan Course	• Correlations by learning outcomes to accrediting bodies such as ABHES, CAAHEP, and CAHIIM • Sample syllabi • Asset map—recap of the key instructor resources as well as information on the content available through *Connect*

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ACKNOWLEDGMENTS

Board of Advisors

A select group of instructors participated in our Coding Board of Advisors. They provided timely and focused guidance to the author team on all aspects of content development. We are extremely grateful for their input on this project.

Christine Cusano, CMA (AAMA), CPhT, Lincoln Technical Institute

Gerry Gordon, BA, CPC, CPB, Daytona College

Shalena Jarvis, RHIT, CCS

Jan Klawitter, AS, CPC, CPB, CPC-I, San Joaquin Valley College

Tatyana Pashnyak, CHTS-TR, Bainbridge State College

Patricia Saccone, MA, RHIA, CCS-P, Waubonsee Community College

Stephanie Scott, MSHI, RHIA, CDIP, CCS, CCS-P, Moraine Park Technical College

Reviews

Many instructors reviewed the manuscript while it was in development and provided valuable feedback that directly affected the product's development. Their contributions are greatly appreciated.

Julie Alles-Grice, MSCTE, RHIA

Alicia Alva, AS, San Joaquin Valley College

Kelly Berge, MSHA, CPC, CCS-P, Berkeley College

Valerie Brock, EdS, MBA, RHIA, CDIP, CPC, Tennessee State University

William Butler, MHA, UNC Healthcare

Heather Copen, RHIA, CCS-P, Ivy Tech Community College

Gerard Cronin, MS, DC, Salem Community College

Christine Cusano, CMA (AAMA), CPhT, Lincoln Technical Institute

Patti Fayash, CCS, ICD-10-CM/PCS AHIMA Approved Trainer, Luzerne County Community College

Rashmi Gaonkar, BS, MS, MHA/Informatics, ASA College

Savanna Garrity, MPA, CPC, Madisonville Community College

Deborah Gilbert, RHIA, MBA, CMA, Dalton State College

Terri Gilbert, MS, ECPI University

Gerry Gordon, BA, CPC, CPB, Daytona College

Michelle A. Harris, CPC, CPB, CPC-I, Bossier Parish Community College

Susan Hernandez, B.S.B.A., San Joaquin Valley College

Judith Hurtt, MEd, East Central Community College

Beverlee Jackson, BA, RHIT, CCS, AHIMA Ambassador, Central Oregon Community College

Shalena Jarvis, RHIT, CCS

Mary Z. Johnston, RN, BSN, RHIA, CPC, CPC-H, CPC-I, Ultimate Medical Academy

Jan Klawitter, AS, CPC, CPB, CPC-I, San Joaquin Valley College

Jennifer Lamé, MPH, RHIT, Southwest Wisconsin Technical College

Jorell Lawrence, MSA, CPC, Stratford University

Tracey Lee, MSA, CPC, Vista College

Angela Leuvoy, AAS, CMA, CPT, CBCS, Fortis College

Glenda Lloyd, MBA, BS, RHIA, Rasmussen College, Vista College

Lynnae Lockett, RN, RMA, CMRS, MSN, Bryant & Stratton College

Marta Lopez, MD, BXMO, RMA, Miami Dade College

JanMarie Malik, MBA, RHIA, CCS-P, National University

Barbara Marchelletta, BS, CMA (AAMA), CPT, CPC, AHI, Beal College

David Martinez, MHSA, RHIT, RMA, University of Phoenix

Jillian McDonald, BS, RMA (AMT), EMT, CPT(NPA)

Cheryl Miller, MBA/HCM, Westmoreland County Community College

Robin Moore, CPC, CCMA, Davis College

Lisa Nimmo, CPC, CFPC, Central Carolina Technical College

Melissa Oelfke, RHIA, HIT Program Coordinator, Rasmussen College

Barbara Parker, CPC, CCS-P, CMA (AAMA), Olympic College

Brenda Parks-Brown, MHS, HCA, CCS, CMA, Miller-Motte Technical College

Tatyana Pashnyak, CHTS-TR, Bainbridge State College

Staci Porter, AA, San Joaquin Valley College

Terri Randolph, MBA/HCM, CAHI, CBCS, CEHRS, Eagle Gate College

Lisa Riggs, CPC, CPC-I, Ultimate Medical Academy

Rolando Russell, MBA, RHIA, CPC, CPAR, Ultimate Medical Academy

Patricia Saccone, MA, RHIA, CCS-P, Waubonsee Community College

Georgina Sampson, RHIA, Anoka Technical College

Stephanie Scott, MSHI, RHIA, CDIP, CCS, CCS-P, Moraine Park Technical College

Mary Jo Slater, MS, MIE, Community College of Beaver County

Karen K. Smith, MEd, RHIA, CDIP, CPC, University of Arkansas for Medical Sciences

Kameron Stutzman, MEd, CMBS, IBMC College

Stephanie Vergne, MAEd, RHIA, CPC, Hazard Community & Technical College

Technical Editing/Accuracy Panel

A panel of instructors completed a technical edit and review of all content in the page proofs to verify its accuracy.

Amber Capell, BS, CPC, CPC-I, Ultimate Medical Academy

Savanna Garrity, MPA, CPC, Madisonville Community College

Susan Holler, MSEd, CPC, CMRS, Bryant & Stratton College

Katurah M. Jones, MPA, MBA, RHIA, AHI, CPC, CPB, Hunter College, New York University

Janis A. Klawitter, AS, CPC, CPB, CPC-I, San Joaquin Valley College

Tracey Lee MSA, CPC, Vista College

Ajay Mehra, BSc, RT(R), CCS-P, RHIT, Rochester Community & Technical College

Corina Miranda, CMPC-I, CMRS, CPC, Northwest Vista College/Alamo Community Colleges

Robin Moore, CPC, CCMA, Davis College

Barbara Parker, CPC, CCS-P, CMA (AAMA), Olympic College

Jerri Rowe, MBA, CFE, RHIA, CPC, CRC, Allen School of Health Sciences

Kathy J Ware, MCLS, RHIT, CPC, CPB, CPC-I, Lord Fairfax Community College

Deborah Zenzal, RN, MSHIM, MS, CPC, CCS-P, RMA

Digital Tool Development

Special thanks to the instructors who helped with the development of Connect and SmartBook.

Tammy L. Burnette, PhD, CPC, CPB, Tyler Junior College

Denise DeDeaux, MBA, Fayetteville Technical College

Judith Hurtt, MEd, East Central Community College

Shalena Jarvis, RHIT, CCS

Shauna Phillips, RMA, CCMA, AHI

Lisa Riggs, CPC, CPC-I, Ultimate Medical Academy

Patricia A. Saccone, MA, RHIA, CCS-P, Waubonsee Community College

Let's Code It!

PART I

MEDICAL CODING FUNDAMENTALS

INTRODUCTION

Coding is not like anything you have ever studied before. No courses that you experienced in elementary, middle, or high school have prepared you for learning this skill. Biology and your science classes began your education that your anatomy and physiology class continued. Other courses you are taking as part of this program also typically connect to something, in some way, you have previously learned.

As you begin this educational journey, you will use your critical thinking skills as well as some experiences you may have had as a patient yourself (or as the loved one of a patient). For the most part, though, this will be different, so prepare yourself for a new learning experience.

In Part I, the chapters Introduction to the Languages of Coding, Abstracting Clinical Documentation, and The Coding Process share an overview of the concepts and skills you will apply in the chapters that follow. You will be introduced to the tools you have and will need to use as a professional coding specialist. Together, these three chapters create the foundation, the first layer, of a multilayered approach to learning coding. Then, the remaining Parts will share with you, one by one, the best practices for how to use each of these tools correctly. You will then be given many opportunities for hands-on practice so that you can build your skills and reinforce the knowledge you have obtained.

1 Introduction to the Languages of Coding

Key Terms

Classification Systems
Condition
Diagnosis
Eponym
External Cause
Inpatient
Medical Necessity
Nonessential Modifiers
Outpatient
Procedure
Reimbursement
Services
Treatments

Learning Outcomes

After completing this chapter, the student should be able to:

LO 1.1 Explain the four purposes of medical coding.
LO 1.2 Identify the structure of the ICD-10-CM diagnosis coding manual.
LO 1.3 Differentiate between the types of procedures and the various procedure coding manuals.
LO 1.4 Examine the HCPCS Level II coding manual used to report the provision of equipment and supplies.

CODING BITES

We use the concept of "*languages*" to help you relate medical coding—and its code sets—to an idea you already understand. In the health care industry, however, the various code sets, such as ICD-10-CM or HCPCS Level II, are referred to as **Classification Systems**.

Classification Systems
The term used in health care to identify ICD-10-CM, CPT, ICD-10-PCS, and HCPCS Level II code sets.

CODING BITES

A **diagnosis** explains WHY the patient requires the attention of a health care provider and a **procedure** explains WHAT the physician or health care provider did for the patient.

1.1 The Purpose of Coding

Around the world, languages exist to enable clear and accurate communication between individuals in similar groups or working together in similar functions. The purpose of using health care coding languages is to enable the sharing of information, in a specific and efficient way, between all those involved in health care.

Coding languages are constructed of individual codes that are more precise than words. (You will discover this as you venture through this textbook.) By communicating using codes rather than words, you can successfully convey to others involved (1) exactly what happened during a provider-patient encounter and (2) why it occurred. You, as the professional coding specialist, have the responsibility to accurately interpret health care terms and definitions (medical terminology) into numbers or number-letter combinations (alphanumeric codes) that specifically convey **diagnoses** and **procedures**.

Why is it so critical to code diagnoses and procedures accurately? The coding languages, known as **classification systems**, communicate information that is key to various aspects of the health care system, including

- Medical necessity
- Statistical analyses
- Reimbursement
- Resource allocation

Medical Necessity

The diagnosis codes that you report explain the justification for the procedure, service, or treatment provided to a patient during his or her encounter. Every time a health

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care professional provides care to a patient, there must be a valid medical reason. Patients certainly want to know that health care professionals performed procedures or provided care for a specific, justified purpose, and so do third-party payers! This is referred to as **medical necessity**. Requiring medical necessity ensures that health care providers are not performing tests or giving injections without a good medical reason. Diagnosis codes explain *why* the individual came to see the physician and support the physician's decision about *what* procedures to provide.

Medical necessity is one of the reasons why it is so very important to code the diagnosis accurately and with all the detail possible. If you are one number off in your code selection, you could accidentally cause a claim to be denied because the diagnosis, identified by your incorrect code, does not justify the procedure.

Let's analyze an example:

Diagnosis
A physician's determination of a patient's condition, illness, or injury.

Procedure
Action taken, in accordance with the standards of care, by the physician to accomplish a predetermined objective (result); a surgical operation.

Medical Necessity
The determination that the health care professional was acting according to standard practices in providing a particular procedure for an individual with a particular diagnosis. Also referred to as medically necessary.

EXAMPLE

Dr. Justini performs a colonoscopy on Shoshanna because a lab test identified that she had blood in her feces (melena).

A colonoscopy involves the insertion of a camera, with surgical tools, into the patient's anus, rectum, and up through the large intestine. If you are Shoshanna, or if you are the one paying for this procedure, you want to make certain that this colonoscopy was done to support Shoshanna's good health and not any other reason. This is clearly communicated when you report the code: K92.1 Melena (the presence of blood in feces). Now, whether for resource allocation or reimbursement, it is understood that Dr. Justini was caring properly for Shoshanna and her good health.

CODING BITES

The WHY justifies the WHAT.

Statistical Analyses

Research organizations and government agencies statistically analyze the data provided by codes to develop programs, identify research areas, allocate funds, and write public health policies that will best address areas of concern for the health of our nation. For example, we can only know that a disease such as Alzheimer's needs diagnostic tests, treatments, and possibly a vaccine or a cure by studying statistics to see what individual signs and symptoms are being identified and treated around the country and around the world.

Reimbursement

Reimbursement
The process of paying for health care services after they have been provided.

In most cases, there are three parties involved in virtually every encounter: the health care provider, the patient, and the person or organization paying for the care provided (frequently, a health care insurance company). However, the insurance company is not always an actual insurance company, so the broader term "third-party payer" is used. Third-party payers use our coding data to determine how much they should pay health care professionals for the attention and services they provide patients. This is the role that coding plays in the **reimbursement** process. The codes make it easier for the organizations involved to evaluate and manage all their data.

CODING BITES

In most cases, there are three parties involved in reimbursement:

- The health care provider = First party
- The patient = Second party
- The insurance company or other organization financially responsible = Third-party payer

Resource Allocations

Whether a health care facility is a one-physician office or a large hospital, there are not unlimited resources available. Administrators and managers must ensure that all resources are employed in the most efficient and effective manner. Computer programs can easily and quickly organize data (the codes) to identify the largest patient population's diagnoses and the most frequently provided treatments and services. With these details, staff members, equipment, and money can be directed to those patients and locations that need them the most.

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1.2 Diagnosis Coding

When a person goes to see a health care provider, he or she must have a reason—a health-related reason. After all, as much as you might like your physician, you probably wouldn't make an appointment, sit in the waiting room, and go through all the paperwork just to say, "hello." Whether the reason is a checkup, a flu shot, or something more serious, there is always a reason *why*. The physician will create notes, either written or dictated, recounting the events of the visit. The diagnosis, or diagnostic statement, in these notes will explain the reason *why* the patient was seen and treated.

The physician's notes explain, in writing, the reasons *why* the encounter occurred. The notes may document a specific condition or illness, the signs or symptoms of a yet-unnamed problem, or another reason for the encounter, such as a preventive service. As a coding specialist, it is your job to translate this explanation into a diagnosis code (or codes) so that everyone involved will clearly understand the issues of a particular patient at a particular time.

The International Classification of Diseases – 10th Revision – Clinical Modification (ICD-10-CM) code book contains all of the codes from which you will choose to report the reason *why* the health care professional cared for the patient during a specific encounter.

Overview of the International Classification of Diseases – 10th Revision – Clinical Modification (ICD-10-CM) Code Book Sections

The ICD-10-CM code book (whether paper or electronic) is made up of several sections. Here is an overview of its parts and how you will utilize the information in these sections to determine the most accurate code or codes to report the reasons *why* an encounter occurred.

Index to Diseases and Injuries [aka Alphabetic Index]

The Alphabetic Index [Index to Diseases and Injuries] lists, in alphabetic order, the terms used by the physician to describe the reasons why the patient required attention from a health care professional.

The Alphabetic Index lists all diagnoses and other reasons to provide health care by their basic description alphabetically from A to Z (see Figure 1-1). Diagnostic descriptions are listed by

- **Condition** (e.g., infection, fracture, and wound)
- **Eponym** (e.g., Epstein-Barr syndrome and Cushing's disease)
- Other descriptors (e.g., personal history, family history)

CODING BITES

This is just an overview to help you orient yourself to the structure of the code book. You will learn, in depth, how to use the ICD-10-CM code set to report any and all of the reasons *why* a patient needs the care of a health care professional in *Part II: Reporting Diagnoses*.

Condition
The state of abnormality or dysfunction.

Eponym
A disease or condition named for a person.

Abnormal, abnormality, abnormalities (*see also* Anomaly)

- acid-based balance (mixed) E87.4
- albumin R77.0
- alphafetoprotein R77.2
- alveolar ridge K08.9
- anatomical relationship Q89.9
- apertures, congenital, diaphragm Q79.1
- auditory perception H93.29-
-- diplacusis — *see* Diplacusis
-- hyperacusis — *see* Hyperacusis
-- recruitment — *see* Recruitment, auditory
-- threshold shift — *see* Shift, auditory threshold
- autosomes Q99.9

FIGURE 1-1 ICD-10-CM Alphabetic Index, partial listing under main term Abnormal

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So, whichever type of words you read in the documentation, you should be able to find them in the Alphabetic Index in one form or another.

The Alphabetic Index can only suggest a possible code to report the patient's diagnosis, and you will use this suggestion to guide you to the correct page or subsection in the Tabular List (see the next subsection of this text, *Tabular List of Diseases and Injuries*). The Official Guidelines require you to always find a suggested code in the Tabular List to confirm it is accurate, or to find another code that might be better.

Tabular List of Diseases and Injuries

The Tabular List provides you with each and every available code in the ICD-10-CM code book, in order of the code characters—alphanumeric order. You need to carefully read the descriptions, beginning at the top of the three-character code category. When you begin reading at this point, you can make certain that you find the best code, to the highest level of specificity, according to the physician's documentation.

You will find that the Tabular List section shows all ICD-10-CM codes, first in alphabetic order and then in numeric order: A00 through Z99.89 (see Figure 1-2), along with additional details (notations and symbols) that guide you to the accurate code.

Ancillary Sections of ICD-10-CM

Neoplasm Table

The Neoplasm Table (Figure 1-3) itemizes all of the anatomical sites in the human body that may develop a tumor (neoplasm). Columns in this table further describe the type of neoplasm and suggest a code that may be accurate. As with other codes suggested by the Alphabetic Index, you will need to go to the Tabular List to look up any code found on the Neoplasm Table to confirm accuracy, additional characters required, and other details before you can determine the accurate code to report.

You will learn how to use the Neoplasm Table to report diagnoses of benign, malignant, and other types of neoplasms in the *Coding Neoplasms* chapter.

Table of Drugs and Chemicals

The Table of Drugs and Chemicals (Figure 1-4) lists pharmaceuticals and chemicals that may cause poisoning or adverse effects in the human body. The multiple columns in this table categorize the intent of how or why the patient became ill from the drug or chemical to suggest a possible code. As with all of these, this suggested code must

B67 Echinococcosis

INCLUDES hydatidosis

B67.0 Echinococcus granulosus infection of liver

B67.1 Echinococcus granulosus infection of lung

B67.2 Echinococcus granulosus infection of bone

B67.3 Echinococcus granulosus infection, other and multiple sites

B67.31 Echinococcus granulosus infection, thyroid gland

B67.32 Echinococcus granulosus infection, multiple sites

B67.39 Echinococcus granulosus infection, other sites

B67.4 Echinococcus granulosus infection, unspecified

Dog tapeworm (infection)

FIGURE 1-2 ICD-10-CM Tabular List, partial list of codes included in code category B67 Echinococcosis

CODING BITES

Notations in the Tabular List help make your coding process more accurate and a bit easier. For example, as you can see in Figure 1-2, the condition represented by code category B67 is Echinococcosis. Now, read the INCLUDES note directly below B67; it reads . . . INCLUDES hydatidosis. This notation lets you know that, if the physician wrote "echinococcosis" or "hydatidosis" in the documentation, this is the correct code category.

In ICD-10-CM, the INCLUDES note provides you with alternative words or phrases that the physician might use that mean the same condition. In English, they are known as synonyms. In ICD-10-CM, they are known as **nonessential modifiers**.

You will learn more about notations in the *Introduction to ICD-10-CM* chapter.

Nonessential Modifiers
Descriptors whose inclusion in the physician's notes are not absolutely necessary and that are provided simply to further clarify a code description; optional terms.

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	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
-abdomen, abdominal	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
--cavity	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
--organ	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
--viscera	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.2
--wall—*see also Neoplasm, abdomen, wall, skin*	C44.509	C79.2-	D04.5	D23.5	D48.5	D49.2
---connective tissue	C49.4	C79.8-	-	D21.4	D48.1	D49.2
---skin	C44.509					
----basal cell carcinoma	C44.519	-	-	-	-	-
----specified type NEC	C44.599	-	-	-	-	-
----squamous cell carcinoma	C44.529	-	-	-	-	-

FIGURE 1-3 The Neoplasm Table from ICD-10-CM, listings for abdominal neoplasms

Substance	Poisoning, Accidental (Unintentional)	Poisoning, Intentional Self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse Effect	Underdosing
Acefylline piperazine	T48.6X1	T48.6X2	T48.6X3	T48.6X4	T48.6X5	T48.6X6
Acemorphan	T40.2X1	T40.2X2	T40.2X3	T40.2X4	T40.2X5	T40.2X6
Acenocoumarin	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516
Acenocoumarol	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516
Acepifylline	T48.6X1	T48.6X2	T48.6X3	T48.6X4	T48.6X5	T48.6X6
Acepromazine	T43.3X1	T43.3X2	T43.3X3	T43.3X4	T43.3X5	T43.3X6
Acesulfamethoxypyridazine	T37.0X1	T37.0X2	T37.0X3	T37.0X4	T37.0X5	T37.0X6
Acetal	T52.8X1	T52.8X2	T52.8X3	T52.8X4	—	—
Acetaldehyde (vapor)	T52.8X1	T52.8X2	T52.8X3	T52.8X4	—	—
- liquid	T65.891	T65.892	T65.893	T65.894	—	—
P-Acetamidophenol	T39.1X1	T39.1X2	T39.1X3	T39.1X4	T39.1X5	T39.1X6
Acetaminophen	T39.1X1	T39.1X2	T39.1X3	T39.1X4	T39.1X5	T39.1X6

FIGURE 1-4 The Table of Drugs and Chemicals from ICD-10-CM, listings from Acefylline piperazine to Acetaminophen
Source: *ICD-10-CM Official Guidelines for Coding and Reporting,* The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS)

be reviewed in the Tabular List to ensure completeness and accuracy before you can report it.

You will learn how to use the Table of Drugs and Chemicals in the chapter *Coding Injury, Poisoning, and External Causes.*

Index to External Causes

External Cause
An event, outside the body, that causes injury, poisoning, or an adverse reaction.

The Index to **External Causes** (Figure 1-5) lists the causes of injury and poisoning. These codes are used to explain *how* a patient got injured and *where* (place of occurrence) he or she was when the injury happened.

As with the other content in the Alphabetic Index, the code or codes shown here are only suggestions and must be confirmed in the Tabular List before you are permitted to report them. You will learn about the importance of reporting these codes as you

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Abandonment (causing exposure to weather conditions) (with intent to injure or kill) NEC X58

Abuse (adult) (child) (mental) (physical) (sexual) X58

Accident (to) X58
- aircraft (in transit) (powered) — *see also* Accident, transport, aircraft
-- due to, caused by cataclysm — *see* Forces of nature, by type
- animal-rider — *see* Accident, transport, animal-rider
- animal-drawn vehicle — *see* Accident, transport, animal-drawn vehicle occupant
- automobile — *see* Accident, transport, car occupant
- bare foot water skier V94.4
- boat, boating — *see also* Accident, watercraft
-- striking swimmer
-- powered V94.11
-- unpowered V94.12
- bus — *see* Accident, transport, bus occupant
- cable car, not on rails V98.0

FIGURE 1-5 The Index to External Causes, first listings including main terms Abandonment, Abuse, and Accident

progress through your learning experience, particularly in the chapter *Coding Injury, Poisoning, and External Causes.*

The Format of ICD-10-CM Codes

A complete, valid ICD-10-CM code will always begin with a 3-character code category: a letter of the alphabet followed by a minimum of 2 characters (either letters or numbers).

E54 **Ascorbic acid deficiency (scurvy)**
O9A **Maternal malignant neoplasms, traumatic injuries, and abuse**

A majority of the codes will require additional characters to communicate more specific information about the patient's condition. When an additional character is needed to complete the code, a symbol to the left of the code in the Tabular List will identify that additional characters are necessary. The symbol may be a bullet ● or it may be a box with a check mark ☑4, depending upon the publisher of your code book. You will find a legend to explain the meaning of each symbol at the bottom of the page in your code book. As you evaluate the options available for the additional character, make certain to place a dot (period) between the third and fourth characters.

Let's take a look at an example together:

☑4 **M17 Osteoarthritis of knee**
M17.0 Bilateral primary osteoarthritis of knee

The symbol to the left of code M17 alerts you that this code requires a 4th character. In looking at the second line of this example (M17.0), you can see that this fourth character shares additional, important information about the patient's condition. It is not enough to communicate that the patient has been diagnosed with osteoarthritis of the knee. You must explain the specific location (from our example, bilateral = both knees) and specific type of condition (from our example, primary osteoarthritis).

ICD-10-CM codes can be as short as three (3) characters and can add additional characters containing more specificity about the patient's condition . . . up to a total of seven (7) characters. These additional characters ensure that as much detail as possible about the patient's condition is communicated accurately and completely.

CODING BITES

When additional characters are required, those codes with fewer characters are invalid. The need for additional characters is mandatory, not a suggestion.

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CODING BITES

You will learn many more details about reporting diagnoses in *Part II: Reporting Diagnoses,* with more in-depth introduction to ICD-10-CM as well as details by body system.

EXAMPLE

The Tabular List shows you which details to abstract from the documentation. All you have to do is keep reading. The portion of the ICD-10-CM Tabular List below shows options for additional characters and the information these characters convey.

S43.3 Subluxation and dislocation of other and unspecified parts of shoulder girdle

S43.30 Subluxation and dislocation of unspecified parts of shoulder girdle
Dislocation of shoulder girdle NOS
Subluxation of shoulder girdle NOS

S43.301 Subluxation of unspecified parts of right shoulder girdle
S43.302 Subluxation of unspecified parts of left shoulder girdle
S43.303 Subluxation of unspecified parts of unspecified shoulder girdle
S43.304 Dislocation of unspecified parts of the right shoulder girdle
S43.305 Dislocation of unspecified parts of the left shoulder girdle
S43.306 Dislocation of unspecified parts of unspecified shoulder girdle

LET'S CODE IT! SCENARIO

MCGRAW GENERAL HOSPITAL

DATE OF ADMISSION: 05/27/18

DATE OF DISCHARGE: 05/28/18

PATIENT: YOUNG, MATTHEW JAMES

HISTORY: Neonate is male, delivered 05/27/2018 at 1915 hours by C-section due to previous C-section. Mother is:

- gravida 2, para 2, AB 1
- blood type B positive
- GBS negative
- hepatitis B surface antigen negative
- rubella immune
- VDRL nonreactive

VITAL SIGNS:
Weight: 6 pounds 9 ounces
Height: 10-1/2 inches
Head circumference: 14 inches

GENERAL:
APGAR = 10 @1 min., 10 @5 min
SKIN: Portwine nevus on right ankle
NEUROLOGIC: Alert, vigorous cry, good tone, nonfocal

DISPOSITION:
The neonate was discharged to his mother. I instructed the mother to phone me PRN. I told her that I want to see both in my office in 10 days for a follow-up.

Let's Code It!

Dr. Michaels delivered Matthew James Young and examined him. Being born is the confirmed reason why the baby needed Dr. Michael's time and expertise. You need to translate the reason *why* into an ICD-10-CM

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diagnosis code. So, begin in the Alphabetic Index of your ICD-10-CM manual. What should you look up? Matthew needed to be examined right after being born, so let's look up:

Birth . . . nothing here that matches.
Next, try: Newborn. We have a match!
Newborn (infant) (liveborn) (singleton) Z38.2

Turn in the Tabular List to this code and begin by reading at the three-character code category:

☑4 Z38 Liveborn infants according to place of birth and type of delivery

NOTE: This category is for use as the principal code on the initial record of a newborn baby. It is to be used for the initial birth record only. It is not to be used on the mother's record.

You know that Matthew was just born, so this note confirms you are in the right place in the code book. Notes, notations, symbols, and other marks in the code book are there to help point you in the right direction and to support your determination of the correct code.

Our next step is to look at the mark to the left of the code . . . it may be a box with a check mark ☑4, it may be a dot ●, or the following lines may just be indented. However your copy of the code book alerts you, it is clear . . . this code needs an additional character. And this is not a suggestion; it is mandatory.

There are three options for a fourth character:

☑5	Z38.0	Single liveborn infant, born in hospital
	Z38.1	Single liveborn infant, born outside hospital
	Z38.2	Single liveborn infant, unspecified as to place of birth

You can see in the record above that Matthew was born in McGraw General Hospital and, therefore, Z38.0 is the most accurate.

But we aren't done yet. There is a symbol to the left of code Z38.0. It is telling you that an additional character is required. Let's look at the two options:

Z38.00	Single liveborn infant, delivered vaginally
Z38.01	Single liveborn infant, delivered by cesarean

Go back to the documentation and read the information provided by the doctor. He noted that Matthew was born via a C-section (the C stands for cesarean).

There are no more symbols or notations here in the Tabular List. Next, double-check the **Official Guidelines, Section 1C. Chapter 21, subsection 12) Newborns and Infants** as well as **Chapter 16, subsection 6) Code all clinically significant conditions.** It appears that there are no further details or codes needed . . . so this is the code.

Good job! You were able to determine that code Z38.01 most accurately reports Matthew's birth. You did it!

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1.3 Procedure Coding

Once the physician has determined the patient's condition or problem, he or she can then establish a treatment plan. Generally, there are three terms used to describe actions that the physician can take to support a patient's good health or to improve a current condition:

Procedures are actions, or a series of actions, taken to accomplish an objective (result). For example, surgically removing a mole or resectioning the small intestine.

Services are actions that will most often involve counseling, educating, and advising the patient, such as discussing test results or sharing recommendations for risk reduction.

Treatments are typically an application of a health care service, such as radiation treatments for tumor reduction or acupuncture.

Services
Spending time with a patient and/or family about health care situations.

Treatment
The provision of medical care for a disorder or disease.